Proposals for BRC Review on Individual and Employer Mandates

Proposal for an Employer Mandate

All employers in firms with 10 or more full time equivalent employees (FTE) who do not offer health insurance coverage or who offer health insurance but do not make a contribution of at least 50% of premium, must contribute a fair share payment of $365/year per full time equivalent employee.

- Part time (less than 40 hours per week), seasonal (16 weeks or less) and temporary workers (90 days or less per year) would be included (counted by dividing hours worked by 2,080)
- Contractors would not be counted in the calculation
- Start up firms would be excluded for the first two years

NOTE: There are 45,606 businesses in the state. 36,139 (79%) employ 1-9 people and so would be exempt from any mandate.

If mandate applies only to businesses with > 10 employees, it will affect 905 business out of 9,467 (10%) businesses that size and 2.0% of all businesses in the state and will generate revenue of $12M*

If mandate applies only to businesses with > 25 employees, it will affect 234 business out of 3,522 (7%) businesses that size and 0.5% of all businesses in the state and will generate revenue of $8.4M*

If mandate applies only to businesses with > 50 employees, it will affect 97 business out of 1,551 (6%) businesses that size and 0.2% of all businesses in the state and will generate revenues of $6.7M*

* estimates are based on :(1) total employees not FTEs; and (2) estimates of employers who do not currently provide coverage; there is no adjustment for employers who might choose to drop coverage and pay instead.

Proposal for An Individual Mandate

All individuals who are legal residents of Maine with incomes at or over 400% FPL ($39,220) must offer proof of health insurance when filing state income tax or pay a penalty of 50% of the monthly premium for the lowest cost DirigoChoice product for which they were eligible for each month without coverage.

NOTE: This proposal would impact about 25,487 uninsured individuals with income > 400% FPL, comprising 23,495 adults and 1,992 children.

Background Information on Employer and Individual Mandates

The Commission discussed the possibility of adopting a joint employer and individual mandate at its meeting on December 11 and requested additional information to help clarify their options.

The Employer Mandate

The purpose of the employer mandate would be to create a level playing field between employers who offer and contribute to health insurance and those who do not. A few states have adopted an employer mandate (in particular Massachusetts and Vermont). Because of a federal law (ERISA) that prohibits state regulation of self-insured employer benefit plans, states cannot directly mandate that self-insured employers offer health insurance. States can require self-insured employers who do not offer health insurance to their employees to pay a fee to the state in lieu of offering coverage, hence the term "pay or play." Many states are considering this approach. A list of 2005 Pay or Play Bills can be found at http://www.ncsl.org/programs/health/payorplay2006.htm

The Vermont plan requires employers to pay $365 per year for every FTE who does not have health insurance. There is an exemption of eight FTEs when the program begins in 2007, which goes down to six in 2009 and four in 2010. The assessment is calculated quarterly; an FTE is an employee who works 40 hours per week for 13 weeks. Employees who work part time, or not for the entire quarter, are converted by dividing their actual hours worked by 520. The amount paid per FTE per year increases at the same rate as the Catamount Health premium. See details and an example at http://www.leg.state.vt.us/HealthCare/H861_Employer_Assessment_Short_Description.pdf

The Massachusetts law requires employers who do not contribute a "fair and reasonable" amount to coverage to pay the state a Fair Share contribution of $295 per year per FTE. Massachusetts regulations define a "fair and reasonable" amount as having 25% of full time (35 hours/week) employees enrolled and an employer contribution of at least 33% of an individual premium). Seasonal workers (sixteen weeks or less), temporary workers (90 days or less per year), and contractors are not counted in the calculation. The Fair Share contribution is determined annually by the state.

Structuring a provider mandate includes the following considerations:

Components	Options	Issues
Which employers are assessed?	▪ Base the assessment on the number of employees without insurance (both offering and non-offering employers) ▪ Base the assessment only on employees of employers who do not offer health insurance	
What size firms are assessed?	▪ All employers ▪ All employers with more than 5,	▪ Small employers are less able to bear the cost

Components	Options	Issues
	10, 25, 50 employees ▪ Large employers only	▪ A high % of employees at small firms are uninsured ▪ Courts have struck down bills that are too limited
Which employees are counted?	▪ All FTEs ▪ All FTEs except contractors and temporary workers ▪ All full time (35 hours/week)	
What special exemptions are applied?	▪ Start ups for first 1-3 years ▪ Not for profit firms ▪ State and local government	
What's the size of the assessment?	▪ A true substitute for coverage ▪ A nominal amount which helps fund coverage	▪ Health insurance is typically 6-9% of payroll ▪ Small numbers discourage ERISA challenges
What's the form of the assessment?	▪ % of payroll ▪ flat annual amount ▪ hourly amount	▪ Flat amounts are easier to administer

The Individual Mandate

One state, Massachusetts, has enacted an individual mandate that requires every individual to have health insurance coverage under the condition that affordable insurance is available. Many other states are beginning to consider such an initiative.

There are six primary issues to consider in designing an individual mandate:

- Who is required to purchase coverage (generally expressed in terms of Federal poverty level or in terms of percent of income that the expenditure would represent)?
- Under what circumstances the requirement would be waived?
- What would constitute the minimum level of coverage (minimal creditable coverage) that must be purchased?
- How the coverage will be provided (i.e., what distribution system will be used – commercial markets or other alternatives)?
- How the mandate will be coordinated with public or other subsidized programs?
- How will the mandate be enforced?

The question of who is required to purchase coverage requires some examination of the question of affordability. For a family of four, a $1,000 per month premium would result in the following required level of income expenditure at various FPL income levels:

	2006 FPL Annual Income Levels for a Family of Four	2007 DirigoChoice Family Health Insurance Premium	% of Income Spent on Health Insurance	With a 50% Employer Contribution*
100% FPL	$ 20,000	$12,000	67%	34%
200% FPL	$ 40,000	$12,000	33%	16%
300% FPL	$ 60,000	$12,000	20%	10%
400% FPL	$ 80,000	$12,000	15%	7.5%
500% FPL	$100,000	$12,000	12%	6%
600% FPL	$120,000	$12,000	10%	5%

* the effective cost could be reduced further by purchasing on a pre-tax basis

The chart clearly illustrates that affordability is a significant problem for those with incomes at or below 300% FPL in the absence of a subsidized product such as DirigoChoice. But for groups with higher income levels, a mandate to buy insurance may be appropriate.

About 33.7% of the uninsured in Maine (about 39,062 people) have incomes above 300% of the Federal Poverty Level. Their age distribution is as follows:

Age	Number	Uninsured Rate within Age/Income Group	Percent of the Total Uninsured
18 - 29	12,022	13.9%	10.4%
20 - 44	10,666	7.3%	9.2%
45 - 59	14,313	7.1%	12.4%
60 - 64	2,061	6.2%	1.8%
Total	39,062	8.4%	33.7%

The employment profile of the uninsured with incomes above 300% of the Federal Poverty Level shows that most are employed, many at relatively large employers.

Employment Status	Number	Uninsured Rate within Business/Income Group	Percent of the Total Uninsured
1 – 24 employees	17,860	16.4%	15.4%
25 – 99 employees	3,848	7.3%	3.3%
100+ employees	9,920	4.3%	8.6%
Not Working	7,019	9.9%	6.1%
Unknown	416	14.2%	0.4%
Total	39,063		33.7%

While the information is not available by income level, a significant number (71%) of the uninsured are employed full time, while another 22% work 20-35 hours per week.

It would be possible to construct a mandate that addressed a subset of employees and firms. It should be recognized that a mandate for those employees to purchase coverage would create additional costs for the employer as well, as uptake increased. The options for structuring the mandate include:

Components	Options	Issues
Who is covered by the mandate?	▪ Every legal resident ▪ Medicaid eligible residents ▪ Low income residents otherwise eligible for BDCC ▪ Higher income residents	▪ The lower the income levels covered by the mandate, the more important it is to address issues of affordability and subsidy
When would the requirement be waived?	▪ If affordable products were not available ▪ In case of medical hardship ▪ In case of other hardships	▪ Individual hardship determinations are cumbersome to administer
What minimum level of coverage is required?	▪ No more than a specified level of income ▪ Minimum coverage focused on catastrophic care ▪ Minimum benefits focused on prevention and ambulatory care	▪ Higher minimum levels raise the cost to employers and employees ▪ Lower minimum levels raise the risk that employers will drop coverage down to those levels
How will coverage be provided?	▪ Through one or more commercial products ▪ Through a state agency/authority that acts as purchaser	▪ Issues of conflicts and potential adverse selection between public and private offerings must be addressed
How will the mandate be coordinated with public program?	▪ Require that enrollees be ineligible for Medicaid ▪ Make Medicaid voluntary	▪ Medicaid is the most cost-effective way to offer coverage to eligible populations, but requiring it will raise state costs
How will the mandate be enforced?	▪ Through the tax system ▪ Through fines ▪ Through employers	▪ The tax system is the most efficient, but may not be relevant to low income enrollees ▪ Employers may resist a mandated role

Mandated individual coverage has the potential to improve the overall risk pool (thus lowering costs) by requiring the participation of the younger and healthier, who are typically disproportionately uninsured. Mandated individual coverage also has the potential to reduce bad debt and charity care in the system, and ultimately to improve health status through better prevention and early interventions. There will still be residual bad debt and free care related to the underinsured and undocumented residents.